5. PEDIATRIC DENTAL HEALTH

Overview

There has been no oral health assessment in the District of Columbia since 1985. However, it is apparent to practicing pediatric and general dentists that the District's children, many of whom are underinsured or uninsured, are lacking in the routine dental care that is afforded most of the nation's children. Not only is dental pain the number one complaint in the offices of school nurses, but dental caries is the number one preventable disease in children. The Centers for Disease Control (CDC) estimate that 20 percent of the nation's children have 80 percent of the tooth decay.

There has been no dental directive for the city since the Bureau of Dental Services was eliminated from the Commission of Public Health in 1989. In 1997, the Department of Health (DOH) was established, but with no dental health component. The clinical service component of the Commission of Public Health was restructured and its management transferred from the newly established DOH to the Public Benefit Corporation. As a result of the restructuring of clinical services (delivered at community and neighborhood health centers and through school-based programs), funding for many dental services has been eliminated. Obviously, residents, particularly children, are experiencing a gap in dental services; this is a critical need to fill.

A second critical priority is to gather baseline data on the dental needs of the District's most vulnerable children and use the information to develop an easily replicable model program for enhancing access to dental caries prevention, education, and treatment for the District's underinsured and uninsured children. This model program could be replicated throughout the city's wards, with special attention to those—Wards 1, 2, 5, 6, 7, and 8—that have the greatest need for services. Oral health 2010 objectives are as follows.

2010 Objectives for the District

5-1. Dental Caries in Children and Youth

Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the percentage of children who have had one or more cavities (filled or unfilled) is no more than 15 percent among children ages 2–4, 40 percent among children ages 6–8, and 55 percent among adolescents age 15. (Baseline: Nationally, between 1988 and 1994, 18 percent of children ages 2–4, 52 percent of children ages 6–8, and 61 percent of adolescents age 15 had experienced dental caries. Local baseline to be established.)

5-2. Decayed Teeth in Children and Youth

Reduce untreated cavities in primary and permanent teeth (mixed dentition) so that the percentage of children with unfilled, decayed teeth is no more than 12 percent among children ages 2–4, 22 percent among children ages 6–8,

and 15 percent among adolescents age 15. (Baseline: Nationally, between 1988 and 1994, 16 percent of children ages 2–4, 29 percent of children ages 6–8, and 20 percent of adolescents age 15 had one or more decayed teeth. Local baseline to be determined.)

5-3. Children with Protective Sealants in Permanent Molar Teeth

Increase to at least 70 percent the percentage of children ages 8 and 14 who have received protective sealants in permanent molar teeth. (Baseline: Nationally, between 1988 and 1994, 23 percent of 8-year-olds and 24 percent of 14-year-olds received sealants in permanent molar teeth. Local baseline to be determined.)

5-4. Caries Screening for 2-Year-Olds

Increase to Early Periodic Screening, Diagnosis and Treatment (EPSDT) rate the proportion of 2-year-olds who receive caries screening by a qualified health professional (e.g., dentist, dental hygienist, pediatrician, or nurse), both for the existence of any observable decay and for counseling on the need to increase sources of fluoride or decrease potentially excessive sources of fluoride, such as unsupervised tooth brushing. (Baseline to be established.)

5-5.Oral Screening for Children Entering School Programs for the First Time

Increase to at least 85 percent the proportion of all children entering school programs for the first time, who have received an oral health screening. Of those children screened and needing referral, increase to at least 25 percent the proportion receiving a referral for necessary diagnostic, preventive, and treatment services. Of those children being referred for treatment, increase to at least 30 percent the proportion beginning treatment within 90 days. (Baseline to be determined.)

5-6. School-based Health Centers with Oral Health Component

Increase to 10 percent the percentage of school-based health centers (prekindergarten through 12th grade) with an oral health component. (This objective has already been achieved and is included as a status indicator.)

5-7. Community-based Health Centers with Oral Health Education and Service Component

Increase to 5 percent the proportion of local community-based health centers that have a direct oral health education and service component. (This objective has already been achieved and is included as a status indicator.)

5-8. Viable System for Recording and Referring Infants and Children with Cleft Lips, Cleft Palates, and Other Craniofacial Anomalies to Craniofacial Anomaly Teams

Ensure that the District of Columbia has a viable system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams. (Baseline: Nationally in 1993, 23 states had systems for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams.)

Comparable National 2010 Objectives

In the federal HEALTHY PEOPLE 2010 PLAM, under *Goal 21: Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services*, comparable 2010 objectives are the following:

21-1 Dental caries experience;

21-2 Untreated dental decay;

21-3 No permanent tooth loss;

21-4 Periodontal diseases;

21-8 Dental sealants;

21-13 School-based health center with an oral health component;

21-14 Health center with oral health service; and

21-15 Referral for cleft lip or palate.

FOCUS AREA: 5. PEDIATRIC DENTAL HEALTH Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
5-1. Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the percentage of children who have had one or more cavities (filled or unfilled) is no more than 15% among children ages 2–4, 40% among children ages 6–8, and 55% among adolescents age 15.	Nationally, between 1988 and 1994, 18% of children ages 2–4, 52% of children ages 6–8, and 61% of adolescents age 15 had experienced dental caries. (Local baseline to be established.)	No more than 15% of children ages 2–4, 40% of children ages 6–8, and 55% of adolescents age 15 have had one or more cavities (filled or unfilled).
5-2. Reduce untreated cavities in primary and permanent teeth (mixed dentition) so that the percentage of children with unfilled, decayed teeth is no more than 12% among children ages 2–4, 22% among children ages 6–8, and 15% among adolescents age 15.	Nationally, between 1988 and 1994, 16% of children ages 2–4, 29% of children ages 6–8, and 20% of adolescents age 15 had one or more decayed teeth. (Local baseline to be determined.)	No more than 12% of children ages 2–4, 22% of children ages 6–8, and 15% of adolescents age 15 have unfilled, decayed teeth.
5-3. Increase to at least 70% the percentage of children ages 8 and 14 who have received protective sealants in permanent molar teeth.	Nationally, between 1988 and 1994, 23% of 8-year-olds and 24% of 14 year-olds received sealants in permanent molar teeth.	At least 70% of children ages 8 and 14 have received protective sealants in permanent molar teeth.

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FOCUS AREA: 5. PEDIATRIC DENTAL HEALTH *(continued)* Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
5-4. Increase to Early Periodic Screening, Diagnosis and Treatment (EPSDT) rate the proportion of 2-year-olds who receive caries screening by a qualified health professional (e.g., dentist, dental hygienist, pediatrician, or nurse) both for the existence of any observable decay and for counseling on the need to increase the source of fluoride or decrease potentially excessive sources of fluoride, such as unsupervised tooth brushing.	Baseline to be established.	The proportion of 2-year-olds who receive caries screening by a qualified health professional for the existence of any observable decay and for counseling on the need to increase the source of fluoride or decrease potentially excessive sources of fluoride is increased to the EPSDT rate.
5-5. Increase to at least 85% the percentage of all children entering school programs for the first time, who have received an oral health screening. Of those children screened and needing referral, increase to at least 25% the proportion receiving a referral for necessary diagnostic, preventive, and treatment services. Of those children being referred for treatment, increase to at least 30% the proportion beginning treatment within 90 days.	Baseline to be determined.	Percentage of all children entering school programs for the first time who have received an oral health screening increased to at least 85%. Of those children screening and needing referral, the proportion receiving a referral increased to at least 25%. Of those children referred for treatment, the proportion beginning treatment within 90 days increased to at least 30%.

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FOCUS AREA: 5. PEDIATRIC DENTAL HEALTH *(continued)* Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
5-6. Increase to 10% the percentage of school-based health centers (prekindergarten through 12th grade) with an oral health component.	This objective has already been achieved and is included as a status indicator.	As of 2000, 10% of school-based health centers have an oral health component.
5-7. Increase to 5% the percentage of local community-based health centers that have a direct oral health education and service component.	This objective has already been achieved and is included as a status indicator.	As of 2000, 5% of local community-based health centers have a direct oral health education and service component.
5-8. Ensure that the District of Columbia has a viable system for recording and referring infants and children with cleft lips, cleft palates, and other cranio-facial anomalies to cranio-facial anomaly teams.	Nationally in 1993, 23 states had systems for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams.	The District has a viable system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams.